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To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.



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PROVIDER INFORMATION NOTICE

PIN: 14 - 05

TITLE: HWLA UNMATCHED ABILITY-TO-PAY (ATP) APPLICATION FOR MY HEALTH LA (MHLA) PILOT SITES

DATE: August 13, 2014

Background

In accordance with the Healthy Way LA Health Care Initiative Unmatched Program Agreement, a patient shall be eligible for the Unmatched Program only after Community Partner has screened the patient for third-party coverage.

Provider Instructions

This is to inform you that effective August 13, 2014 it is permissible under the HWLA Unmatched Program to screen the patients utilizing the electronic eligibility determination and enrollment system (One-E-App) for new and renewing patients.

Therefore, the print out of the One-E-App application summary must be attached to the ATP Application. The ATP Application must be signed by the patient and the eligibility period must be completed, and a line is to be drawn across the top of the application with the wording "SEE ATTACHED OEA SUMMARY SHEET" (see attached example).

If you have any questions or need further information, please contact your Program Advocate.

Tangerine M. Brigham
Deputy Director, Managed Care Services
Los Angeles County Department of Health Services

**COUNTY OF LOS ANGELES – DEPARTMENT OF HEALTH SERVICES
COMMUNITY PARTNERS – ABILITY-TO-PAY PLAN APPLICATION
HWLA UNMATCHED**

Name of facility taking this Application: _____

Patient: _____ MRUN #: _____ Account # _____ Visit Date: _____

FAMILY MEMBERS IN HOME Name	BIRTHDATE Month / Day / Year	Birthplace	EMPLOYED Yes / No	Social Security Number
1 (Adult)				
2 (Adult)				
3				
4				
5				
6				

Address: _____ Telephone No.: (____) _____

Number/Street City State Zip Code

Los Angeles County Resident: Yes ☐ or No ☐

INCOME EVALUATION:

Earned Income: \$ _____

Family Size: _____

+ Unearned Income: \$ _____

= **Total Monthly Income** (Earned + Unearned): \$ _____

Is patient at or below 138% FPL? ☐ Yes or ☐ No

It has been preliminarily determined that the Total Adjusted Gross Monthly Income is at or below 138% of the Federal Poverty Level. Therefore, subject the income stated above, all outpatient services received by the patient covered by the application from _____ through _____ are with zero liability.

I/we understand and agree that this Application is made as part of the County's Unmatched Program which helps low income individuals pay for medical care.

If the patient gets or loses insurance, or if his or her family size or income changes, I/we promise to immediately report that fact to the facility where this Application was completed. I/we further agree that if I/we have any other change in financial circumstances, including but not limited to an increase in the guarantor's income, or the patient, or patient's heirs or personal representative(s) receipt of damages recovered as a result of patient's injury by accident, negligence, or wrongful act, I/we will notify the facility where this Application was completed. This Application may, at the election of the County of Los Angeles, be terminated.

Pursuant to Section 360.5 of the California Code of Civil Procedure, which allows written waivers related to actions for the repayment of County aid, I/we agree that all statutes of limitation upon all debts related to the health care services covered by this Application are hereby waived. This Application shall not in any way diminish or defeat the County's rights which may exist under California Government Code sections 23004.1 and 23004.2, or the Hospital Lien Act, or any other applicable laws, to recover reimbursement from any responsible third-parties, including tortfeasors, the reasonable charges for health care services provided to the patient.

I/WE CERTIFY UNDER PENALTY OF PERJURY BY MY/OUR SIGNATURE(S) THAT THE INFORMATION I/WE HAVE PROVIDED AS REQUESTED IN THIS AGREEMENT IS TRUE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE AND BELIEF. I/WE ALSO CERTIFY BY MY/OUR SIGNATURES THAT I/WE HAVE READ AND UNDERSTAND ALL THE FORGOING AND THAT I/WE AGREE TO SIGN THIS STATEMENT WITHOUT ANY RESERVATION WHATSOEVER.

Patient's Signature

Date

Interviewer's Signature

Date

Responsible Relative Signature

Date